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Policy analysis

The evidence does not speak for itself: The role of research evidence in shaping policy change for the implementation of publicly funded syringe exchange programs in three US cities

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ABSTRACT

Background: A breadth of literature exists that explores the utilization of research evidence in policy change processes. From this work, a number of studies suggest research evidence is applied to change processes by policy change stakeholders primarily through instrumental, conceptual, and/or symbolic applications, or is not used at all. Despite the expansiveness of research on policy change processes, a deficit exists in understanding the role of research evidence during change processes related to the implementation of structural interventions for HIV prevention among injection drug users (IDU). This study examined the role of research evidence in policy change processes for the implementation of publicly funded syringe exchange services in three US cities: Baltimore, MD, Philadelphia, PA, and Washington, DC.

Methods: In-depth qualitative interviews were conducted with key stakeholders ($n = 29$) from each of the study cities. Stakeholders were asked about the historical, social, political, and scientific contexts in their city during the policy change process. Interviews were transcribed and analyzed for common themes pertaining to applications of research evidence.

Results: In Baltimore and Philadelphia, the typological approaches (instrumental and symbolic/conceptual, respectively) to the applications of research evidence used by harm reduction proponents contributed to the momentum for securing policy change for the implementation of syringe exchange services. Applications of research evidence were less successful in DC because policymakers had differing ideas about the implications of syringe exchange program implementation and because opponents of policy change used evidence incorrectly or not at all in policy change discussions.

Conclusion: Typological applications of research evidence are useful for understanding policy change processes, but their efficacy falls short when sociopolitical factors complicate legislative processes. Advocates for harm reduction may benefit from understanding how to effectively integrate research evidence into policy change processes in ways that confront the myriad of factors that influence policy change.

Background

Public health literature suggests that policies should reflect consideration of research evidence; unfortunately, the manifestation of evidence in policy processes is complicated by a number of sociopolitical and structural factors that result in it not being used to the extent that it could in theory (Brownson, Royer, Ewing, & Mcbride, 2006; Davis & Howden-chapman, 1996; Edwards, 2005; Frenk, 1992; Hanney, Gonzalez-Block, Buxton, & Kogan, 2003; Nutley, Walter, & Davies, 2003; Ritter, 2011; Trostle, Bronfman, & Langer, 1999). Policymakers may struggle to implement evidence-based policies while simultaneously addressing the priorities of their electorate. In some cases, policymakers are presented with research evidence that they cannot easily understand (e.g., information is presented using too much scientific jargon) or utilize (e.g., information is provided at a time when opportunities for policy change are not present) (Brownson et al., 2006; Brownson, Chriqui, & Stamatakis, 2009; Mcbride et al., 2008). Policy change related to the implementation of harm reduction strategies – such as syringe exchange programs (SEPs) – has been especially slow moving, a fact that is not surprising given the stigmatization of injection drug users (IDU) (Ross & Darke, 1992)

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and the politics of drug policy (Ritter, 2011). As Ritter noted, "...the politics of drug policy can be either 'zero tolerance' or 'harm reduction'. For the former, drug policy signifies a moral statement by government against drug use... ...For harm reduction, government's role is to protect society from the consequences of drug use, but not to eliminate drug use itself..." (Ritter, 2011).

Though policymakers may have varying opinions on the merits and moral obligations of expanding services to meet the needs of IDU, there is a body of research documenting the utility and cost-effectiveness of implementing SEPs and other harm reduction services for this population. Research shows that SEPs are effective in reducing HIV incidence as well as injection-related practices that increase HIV and HCV risk (Gibson et al., 2002; Kerr et al., 2010; Ksobiech, 2003; Palmateer et al., 2010; Watters, Estilo, Clark, & Lorvick, 1994; Wodak & Cooney, 2006; Wodak & Mcleod, 2008). Unfortunately, legislative barriers, such as paraphernalia laws, funding restrictions, and operational restrictions, impede the widespread implementation of these programs. As the evidence of benefit continues to grow, harm reduction proponents are often puzzled as to why policies do not align with the evidence that shows the social, public health, and financial benefit of expanding such services.

In efforts to confront the health disparities among the estimated 15.9 million people who inject drugs globally (Mathers et al., 2008), 86 countries have implemented SEPs (Harm Reduction International, 2012). Unfortunately, access to harm reduction services is not equal in all parts of the world and most low and middle-income countries do not implement SEPs at coverage levels necessary to stabilize and reverse HIV epidemics among IDU (Harm Reduction International, 2012). For example, although it is estimated that there are approximately 3,476,500 people (range: 2,540,000–4,543,500) in Eastern Europe who inject drugs (Harm Reduction International, 2012), yet only 10% of IDU in this region access SEPs (Stuikyte, Votyagov, & Pinkham, 2012). Given the behavioral complexities of substance use and addiction and that the global provision of harm reduction services is suboptimal, structural level interventions, including policy reform processes that allow for the implementation of comprehensive harm reduction services, offer significant benefit for IDU. In order to secure policy reform that supports such interventions, policy-makers, their constituencies, and SEP providers must overcome a number of legal barriers.

Although there is empirical evidence that SEPs do not increase substance use, crime, or the numbers of discarded syringes found in public locations (e.g., streets, parks) (Watters et al., 1994; Wodak & Cooney, 2006; Wodak & Mcleod, 2008), policy change discussions related to their implementation may be clouded by community stakeholder fears and concerns. These discussions may benefit from policymakers' utilization of research evidence as a means to dispel reservations about implementing syringe exchange services. Unfortunately, research evidence may be underutilized by policymakers and is subject to a range of factors that influence its utilization (Brownson et al., 2006; Davis & Howden-chapman, 1996; Edwards, 2005; Frenk, 1992; Hanney et al., 2003; Nutley et al., 2003; Ritter, 2011; Trostle et al., 1999). Further complicating the issue is the fact that policymakers must take into account the amount of political capital available for advancing policies and how to achieve compromise among the legislature (Brownson et al., 2006).

In light of the complexities of applying research evidence to policy change processes, it is important to determine how and in what context research evidence is used by policy stakeholders in legislative reform processes for the expansion of structural-level interventions for public health. There are a number of frameworks in the public health literature that have been used to describe this process. Of greatest relevance to the example of harm reduction and, more specifically, syringe exchange, is the operationalization framework provided by Weiss et al., who state research evidence can be applied to the policy change process in three ways – instrumentally, conceptually, or symbolically – or not at all (Weiss, Graham, & Birkeland, 2005). These typologies, and variants of them, are frequently referenced in health policy and evaluation research (Amara, Ouimet, & Landry, 2004; Cousins & Leithwood, 1986; Field, Gauld, & Lawrence, 2012; Greene, 1988; Landry, Amara, & Lamari, 2001; Lavis et al., 2002; Leviton & Hughes, 1981; NRC, 2012; Turnbull, 1998; Weiss & Weiss, 1981; Weiss et al., 2005; Weiss, 1979).

When research evidence is applied in an instrumental manner to policy change processes, it forms the basis of decision making and gives direction to policy (Weiss et al., 2005). However, research has found that policymakers rarely apply research evidence *exclusively* in an instrumental manner and that they view instrumental use as only one way in which research can be used in policy development (Weiss & Weiss, 1981); for example, a study among professionals and managers in Canadian and provincial government agencies found that multiple applications of research evidence simultaneously played a role in the agencies (Amara et al., 2004). The lack of exclusive instrumental application of research evidence may be explained by the fact that research must be negotiated in the contexts of other competing factors in the policy change environment and that its effectiveness is dependent on the contextual factors surrounding the legislative body, such as the willingness of policymakers to rely on evidence in policy processes.

Conceptual use of research evidence occurs indirectly when evidence diffuses into the population and, overtime, influences policy processes by changing ideas and understandings (Weiss et al., 2005). This application of research evidence may be especially useful for understanding policy change processes related to HIV prevention for IDU due to the stigmatized nature of the population (i.e. conceptual shifts in perceptions of IDU may be required for policies to advance that are not biased by stigmatization). The importance of the conceptual understanding of a problem in policy processes was illustrated by a study that suggested methadone maintenance therapy (MMT) signified different ideas among policy change actors (e.g. MMT was viewed as a manifestation of cynicism and misanthropy or as a logical strategy to combat problems stemming from addiction) (Johnson & Hagstrom, 2005). In scenarios pertaining to IDU health, such as changing policies for the implementation of SEPs, conceptual applications of research evidence may offer great value by shifting how addiction and treatment of addiction is understood among the legislature.

Symbolic use of research evidence occurs when stakeholders use evidence as a means to provide legitimization for preexisting preferences and actions (Weiss et al., 2005). Evidence can be used to justify policies that were created based on intuition or specific personal or organizational interests (Weiss et al., 2005). Symbolic applications of research evidence may be of notable relevance to situations where policy changes are necessary to advance the health and well-being of marginalized populations (such as IDU) or address health issues (e.g., mental illness, substance use, and addiction) that are stigmatized and/or misunderstood – and therefore not supported – by the general constituency. In these scenarios, political leaders may apply research evidence symbolically as a means of justifying policy decisions to their constituents. According to Weiss et al., these typologies "capture much of the experience in the empirical literature and practical experience" in the role of research evidence in shaping health policies (Weiss et al., 2005).

Although existing literature has documented how policymakers access research evidence and barriers to its utilization (Brownson et al., 2006, 2009; Ritter, 2009), surprisingly little work has been done to examine how research evidence has been utilized in the